



# REPORT OF TRAINING

State Form 44848 (R/3-94)

Course number

## COURSES (check one)

- |  |   |
|--|---|
| <input type="checkbox"/> First Responder                       | <input type="checkbox"/> Emergency Vehicle Operations |
| <input type="checkbox"/> Emergency Medical Technician          | <input type="checkbox"/> Extrication                  |
| <input type="checkbox"/> Advanced Emergency Medical Technician | <input type="checkbox"/> Update Course                |
| <input type="checkbox"/> Paramedic                             | <input type="checkbox"/> Other                        |

**INSTRUCTIONS:** Submit this report to verify successful completion. Failure to complete any item will result in the form being rejected. Upon acceptance, this form will become a public record.

Name of institution or approved instructor				County	
Address (street, number or Rural Route)			City		ZIP code
Location of course					
Address (street, number or Rural Route)			City		ZIP code
Starting date (month, day, year)		Completion date (month, day, year)		Number of students starting	
				Number of students completing	
Number of classes held		Total course hours		Number of classroom hours	
				Number of clinical hours	
				Number of internship hours	
<b>FIRST RESPONDER (must be reported within 15 days of course completion)</b>					
Name of training institution official (printed)					
Signature of training institution official				Date signed (month, day, year)	
Name of primary instructor (printed)					
Signature of primary instructor				Date signed (month, day, year)	
Signature of Medical Director				Date signed (month, day, year)	
<b>EMERGENCY MEDICAL TECHNICIAN (must be completed prior to written examination along with Practical Skills examination. Keep on file a list of evaluators for Practical Skills examination)</b>					
Name of training institution official (printed)					
Signature of training institution official				Date signed (month, day, year)	
Name of primary instructor (printed)					
Signature of primary instructor				Date signed (month, day, year)	
Name of Medical Director (printed)					
Signature of Medical Director				Date signed (month, day, year)	
<b>ADVANCED EMT AND PARAMEDIC (must be completed prior to written examination)</b>					
Name of curriculum coordinator (printed)					
Signature of curriculum coordinator				Date signed (month, day, year)	
Name of Medical Director (printed)					
Signature of Medical Director				Date signed (month, day, year)	
Signature of institution official				Date signed (month, day, year)	
<b>EMERGENCY VEHICLE OPERATION (must be completed and submitted within 15 days following course completion. Written examination must be submitted.)</b>					
Location of driving range					
Signature of approved driving instructor				Date signed (month, day, year)	
<b>EXTRICATION (must be completed and submitted within 15 days following completion.)</b>					
Signature of approved extrication instructor				Date signed (month, day, year)	

**List all students enrolled in the course.**

Student Name	County	Age	Certification Number		
Address (Street, Number or Rural Route)	<input type="checkbox"/> Initial Certification <input type="checkbox"/> Recertification	Score	Didactic	Clinical	Internship
City, State, ZIP code	EMS Affiliation		Social Security Number		

  

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